FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038612

Facility Name: DEAUVILLE NURSING HOME, INC.

Address: 7445 N. SHERIDAN RD. (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: 773-338-3300 **Fax #** 773-338-5868

IDPA ID Number: 36-3853042

Date of Initial License for Current Owners: 7/01/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) DANIEL SHABAT

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) DONALD MAGNUSON

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,666	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,534	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,860	636	1,647	12,143	8
9	SNF/PED					9
10	ICF	20,954	2,713		23,667	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,814	3,349	1,647	35,810	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.67%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/01/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/01/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1,374

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	151,121	16,399	5,015	172,535		172,535		172,535			1
2	Food Purchase		178,467		178,467	(30,085)	148,382	(166)	148,216			2
3	Housekeeping	81,854	12,674		94,528		94,528		94,528			3
4	Laundry	32,894	13,727		46,621		46,621		46,621			4
5	Heat and Other Utilities			89,042	89,042		89,042		89,042			5
6	Maintenance	36,971	14,102	150,576	201,649		201,649	(64,170)	137,479			6
7	Other (specify):*											7
8	**TOTAL General Services**	302,840	235,369	244,633	782,842	(30,085)	752,757	(64,336)	688,421			8
	B. Health Care and Programs											
9	Medical Director			5,200	5,200		5,200		5,200			9
10	Nursing and Medical Records	858,116	37,168	72,655	967,939		967,939		967,939			10
10a	Therapy	46,528		4,860	51,388		51,388		51,388			10a
11	Activities	46,930	3,403	4,100	54,433		54,433		54,433			11
12	Social Services	34,631		5,759	40,390		40,390		40,390			12
13	Nurse Aide Training											13
14	Program Transportation			327	327		327		327			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	986,205	40,571	92,901	1,119,677		1,119,677		1,119,677			16
	C. General Administration											
17	Administrative	67,715		241,807	309,522		309,522	3,461	312,983			17
18	Directors Fees											18
19	Professional Services			136,895	136,895	(302)	136,593	(8,755)	127,838			19
20	Dues, Fees, Subscriptions & Promotions			31,003	31,003		31,003	(20,335)	10,668			20
21	Clerical & General Office Expenses	89,099	12,105	222,350	323,554		323,554	(192,445)	131,109			21
22	Employee Benefits & Payroll Taxes			226,597	226,597	30,085	256,682	(9,000)	247,682			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,483	2,483		2,483		2,483			24
25	Other Admin. Staff Transportation			1,841	1,841		1,841		1,841			25
26	Insurance-Prop.Liab.Malpractice			45,965	45,965		45,965		45,965			26
27	Other (specify):*							429	429			27
28	**TOTAL General Administration**	156,814	12,105	908,941	1,077,860	29,783	1,107,643	(226,645)	880,998			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,445,859	288,045	1,246,475	2,980,379	(302)	2,980,077	(290,981)	2,689,096			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

DEAUVILLE NURSING HOME, INC.
0038612
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	30,085	
2	FOOD		30,085

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	302	
19	PROFESSIONAL FEES		302

To reclass cost of appealing real estate taxes

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. #0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			40,548	40,548		40,548	28,751	69,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,942	32,942		32,942	196,300	229,242			32
33	Real Estate Taxes			200,612	200,612	302	200,914		200,914			33
34	Rent-Facility & Grounds			395,372	395,372		395,372	(395,372)				34
35	Rent-Equipment & Vehicles			666	666		666		666			35
36	Other (specify):*											36
37	**TOTAL Ownership**			670,140	670,140	302	670,442	(170,321)	500,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,566	53,334	89,900		89,900		89,900			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,801	81,801		81,801		81,801			42
43	Other (specify):*	30,133			30,133		30,133	(30,133)				43
44	**TOTAL Special Cost Centers**	30,133	36,566	135,135	201,834		201,834	(30,133)	171,701			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,475,992	324,611	2,051,750	3,852,353		3,852,353	(491,435)	3,360,918			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,816	30		9
10	Interest and Other Investment Income	(11,521)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(166)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(775)	21		18
19	Entertainment	(6,948)	20		19
20	Contributions	(4,300)	20		20
21	Owner or Key-Man Insurance	(9,000)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(187,665)	21		24
25	Fund Raising, Advertising and Promotional	(8,830)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,005)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(110,373)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (322,767)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(168,668)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (168,668)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (491,435)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

DEAUVILLE NURSING HOME, INC.

ID# 0038612

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	PROFESSIONAL FEE-BUILDING CO	(1,200)	19	2
3	AMORTIZATION OF MORTGAGE FEE	(5,858)	36	3
4	MARKETING SALARY	(30,133)	43	4
5	ASSET ON CR, EXP ON FS-LIMP	(53,621)	6	5
6	ASSET ON CR, EXP ON FS-EQIP	(10,549)	6	6
7	PRIOR YEAR LEGAL	(8,755)	19	7
8	COPE (POLITICAL EDUCATION) CONTRIBUTION	(257)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(110,373)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(166)											(166)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(64,170)											(64,170)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(64,336)											(64,336)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			3,461									3,461	17
18	Directors Fees													18
19	Professional Services	(9,955)	1,200										(8,755)	19
20	Fees, Subscriptions & Promotions	(20,335)											(20,335)	20
21	Clerical & General Office Expenses	(192,445)											(192,445)	21
22	Employee Benefits & Payroll Taxes	(9,000)											(9,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			429									429	27
28	**TOTAL General Administration**	(231,735)	1,200	3,890									(226,645)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(296,071)	1,200	3,890									(290,981)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	20,816	7,935										28,751	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,521)	207,821										196,300	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(395,372)										(395,372)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(5,858)	5,858											36
37	**TOTAL Ownership**	3,437	(173,758)										(170,321)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(30,133)											(30,133)	43
44	**TOTAL Special Cost Centers**	(30,133)											(30,133)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(322,767)	(172,558)	3,890									(491,435)	45

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		PRO HEALTHCARE	BUFFALO GROVE	MGMT CO
				DEAUVILLE	CHICAGO	BUILDING CO
				HEALTHCARE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 395,372	DEAUVILLE HEALTHCARE	100.00%	$	$ (395,372)	1
2	V	33	RENT-REAL ESTATE TAX	200,612	DEAUVILLE HEALTHCARE	100.00%		(200,612)	2
3	V	19	PROFESSIONAL FEES		DEAUVILLE HEALTHCARE	100.00%	1,200	1,200	3
4	V	33	REAL ESTATE TAX		DEAUVILLE HEALTHCARE	100.00%	212,384	212,384	4
5	V	33	REAL ESTATE TAX-PR YR		DEAUVILLE HEALTHCARE	100.00%	(11,772)	(11,772)	5
6	V	30	DEPRECIATION		DEAUVILLE HEALTHCARE	100.00%	7,935	7,935	6
7	V	32	INTEREST EXPENSE		DEAUVILLE HEALTHCARE	100.00%	208,075	208,075	7
8	V	36	AMORT. OF MORT. COST		DEAUVILLE HEALTHCARE	100.00%	5,858	5,858	8
9	V	32	INTEREST INCOME		DEAUVILLE HEALTHCARE	100.00%	(254)	(254)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 595,984			$ 423,426	$ * (172,558)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 9,941	$ 9,941	15
16	V	27	PAYROLL TAXES		PRO HEALTH CARE, INC.	100.00%	429	429	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MANAGEMENT FEES	6,480	PRO HEALTH CARE, INC.	100.00%		(6,480)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,480			$ 10,370	$ * 3,890	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STAN ARON	OWNER	ADMIN	7.22%	SEE ATTACHED	3	4.60%	ALLOC-PRO	$ 9,941	17-7	1
2	SYLVIA HERLIHY	ADMINISTRATIVE	ADMIN	NONE	SEE ATTACHED	15	25.00%				2
3	DANIEL SHABAT	OWNER	ADMIN	18.05%	SEE ATTACHED	35	58.33%	MGT FEE	235,327	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 245,268		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1									$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60015
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 169,000	$ 169,000	3	$ 9,941	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	7,285		3	429	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,285	$ 169,000		$ 10,370	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ROYAL GARDENS		X	MORTGAGE	$10,458.00	1/1/84	$ 2,361,650	$ 1,018,858	8/1/11	11.00%	$ 88,209	1
2	MID NORTH		X	MORTGAGE	$22,733.00	9/1/90	2,000,000	784,629	10/1/05	11.00%	119,866	2
3	1ST BANK OF EVANSTON		X	AUTO LOAN	$854.58	11/1/99	18,800	9,013	11/1/01	8.50%	1,189	3
4												4
5												5
	Working Capital											
6	SHAREHOLDER LOAN	X		WORKING CAPITAL	NONE	11/2/92	500,000	500,000	12/31/00	IRS RATE	31,753	6
7												7
8												8
9	TOTAL Facility Related				$34,045.58		$ 4,880,450	$ 2,312,500			$ 241,017	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME										(11,521)	11
12	ALLOC INT. INC-DEAU HC										(254)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,775)	14
15	TOTALS (line 9+line14)						$ 4,880,450	$ 2,312,500			$ 229,242	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	217,971	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	206,198	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,773)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	212,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	302	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 387 For 19 94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	200,913	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	198,516	8
	1996	203,400	9
	1997	203,971	10
	1998	207,591	11
	1999	206,198	12

1999 TAX INCREASED 3% FOR INFLATION
$206,198 * 1.03 = $212,384
THE 1994 REFUND WAS NOT OFFSET ON LINE 6 BECAUSE THE REFUND APPLIED TO A YEAR WHEN THE REAL ESTATE TAXES WERE NOT USED TO DETERMINE THE RATE.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,216 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NA

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 196,188	1
2					2
3	TOTALS			$ 196,188	3

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	149		1984		$ 2,183,550	$	15	$	$	$ 2,183,550	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	63,831	1,636	20	3,192	1,556	22,647	9
10	Various			1994	33,446	378	20	1,672	1,294	11,141	10
11	Various			1995	40,581	696	20	2,029	1,333	11,816	11
12	ELECTRICAL EQUIP			1996	750	19	20	38	19	165	12
13	ELECTRIC LINE			1996	1,050	27	20	53	26	216	13
14	LIGHT FIXTURES			1996	730	19	20	37	18	160	14
15	RANGE GUARD SYS.			1996	1,599	41	20	80	39	393	15
16	LIGHT FIXTURE			1996	767	20	20	38	18	162	16
17	SINK			1996	500	13	20	25	12	125	17
18	ROOF			1996	14,000	359	20	700	341	3,325	18
19	SUMP PUMP INSTALL			1997	1,085		20	54	54	212	19
20	CURTAINS			1997	3,891		20	195	195	731	20
21	BOILER			1997	967		20	48	48	192	21
22	CANOPY			1997	1,721		20	86	86	308	22
23	MOTORS			1997	1,155		20	58	58	218	23
24											24
25	PAGE 12-1 REP TOTALS				279,801	7,935		9,923	1,988	209,796	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				24,047			743	743	743	32
33	PAGE 12C TOTALS				33,671	32		1,168	1,136	1,168	33
34	PAGE 12B TOTALS				109,166	922		4,348	3,426	5,818	34
35	PAGE 12A TOTALS				118,036	2,042		5,904	3,862	19,932	35
36	TOTAL (lines 4 thru 35)				$ 2,914,344	$ 14,139		$ 30,391	$ 16,252	$ 2,472,818	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING			1997	2,985		20	149	149	546	9
10	EMERGENCY GENERATOR			1997	79,650	2,042	20	3,983	1,941	14,272	10
11	BOILER REPAIR			1997	506		20	25	25	100	11
12	FIRE ALARM SYS			1997	1,798		20	90	90	345	12
13	GENERATOR & PUMP			1997	625		20	31	31	121	13
14	PAINT			1997	700		20	35	35	125	14
15	SHANNON-REPAI			1997	770		20	39	39	140	15
16	ELEVATOR REPAIR			1997	1,000		20	50	50	163	16
17	WINDOW SCREENS			1997	1,183		20	59	59	207	17
18	SUMP PUMP			1997	700		20	35	35	140	18
19	SUMP PUMP-STARTER			1997	852		20	43	43	172	19
20	PLUMBING-PIPES			1998	975		20	49	49	123	20
21	BATHROOM DOORS			1998	1,185		20	59	59	162	21
22	PARKING-ASPHALT			1998	2,833		20	142	142	367	22
23	MAGNET DOOR			1998	800		20	40	40	117	23
24	PATIENT DOORS			1998	3,680		20	184	184	506	24
25	SAFETY CODE REVIEW			1998	2,252		20	113	113	339	25
26	GENERATOR-100 AMP			1998	3,145		20	157	157	432	26
27	ELECTRICAL LINES			1998	975		20	49	49	110	27
28	STAIRWAY RAILINGS			1998	660		20	33	33	69	28
29	FIRERATED DOOR			1998	750		20	38	38	82	29
30	WALLPAPER			1998	1,000		20	50	50	142	30
31	ELEVATOR DOOR RESTRI			1998	2,400		20	120	120	320	31
32	SUMP PUMP			1998	2,500		20	125	125	365	32
33	ELEV.INFRARED DOOR			1998	1,750		20	88	88	213	33
34	FIRE DAMPERS			1998	1,528		20	76	76	177	34
35	ARCHITECT			1999	834		20	42	42	77	35
36	TOTAL (lines 4 thru 35)				$ 118,036	$ 2,042		$ 5,904	$ 3,862	$ 19,932	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1999		910	20		(910)		9
10	FIRE DAMPERS			1999	1,750		20	88	88	169	10
11	FIRE DAMPERS			1999	5,300		20	265	265	486	11
12	BASE DRYWALL			1999	722		20	36	36	57	12
13	ELECTRIC OUTLET			1999	650		20	33	33	44	13
14	DOORS			1999	3,465		20	173	173	231	14
15	DOORS			1999	5,280		20	264	264	352	15
16	HOSPICE REMODELING			1999	4,000		20	200	200	233	16
17	DRYWALL			1999	2,800		20	140	140	268	17
18	DRYWALL			1999	630		20	32	32	56	18
19	BATH TUB IMPROVEMENT			1999	1,550		20	78	78	130	19
20	WALLPAPER			1999	4,814		20	241	241	321	20
21	PAINTING			1999	18,828		20	941	941	1,019	21
22	WALLPAPER			1999	3,172		20	159	159	252	22
23	WALLPAPER			1999	1,584		20	79	79	105	23
24	DRAPERIES			1999	437		20	22	22	31	24
25	CARPET			1999	802		20	40	40	57	25
26	WALLPAPER			1999	190		20	10	10	14	26
27	NURSING STATION			1999	3,325		20	166	166	194	27
28	WALLPAPER			1999	480		20	24	24	30	28
29	WALLPAPER			1999	2,878		20	144	144	216	29
30	WINDOW TREATMENT			1999	13,458		20	673	673	897	30
31	ARCHITECT			1999	3,103		20	155	155	271	31
32	ELEVATOR MOTOR			2000	1,065		20	27	27	27	32
33	GENERATOR DUCT			2000	750		20	32	32	32	33
34	CORRIDOR RAILINGS			2000	11,473	12	20	48	36	48	34
35	WARDROBES			2000	16,660		20	278	278	278	35
36	TOTAL (lines 4 thru 35)				$ 109,166	$ 922		$ 4,348	$ 3,426	$ 5,818	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HOT WATER HEATER			2000	3,860		20	177	177	177	9
10	CORRIDOR RAILINGS			2000	5,913	32	20	74	42	74	10
11	DOOR			2000	806		20	37	37	37	11
12	DOORS			2000	1,500		20	69	69	69	12
13	LIGHT FIXTURES			2000	875		20	37	37	37	13
14	PAINTING			2000	574		20	24	24	24	14
15	LIGHT FIXTURES			2000	2,250		20	75	75	75	15
16	PAINTING			2000	179		20	7	7	7	16
17	GENERATOR DUCT			2000	750		20	32	32	32	17
18	KEYPAD ALARM			2000	891		20	26	26	26	18
19	TOILET			2000	525		20	4	4	4	19
20	FLOORING			2000	1,408		20	29	29	29	20
21	PAINTING			2000	217		20	1	1	1	21
22	CURTAINS			2000	4,908		20	245	245	245	22
23	CARPETING			2000	601		20	25	25	25	23
24	PAINTING			2000	916		20	35	35	35	24
25	BOILER ROOM PIPING			2000	2,000		20	92	92	92	25
26	CARPET BORDER			2000	44		20	1	1	1	26
27	BOILER RM INSULATION			2000	3,000		20	113	113	113	27
28	WALL-BASE COVERING			2000	305		20	8	8	8	28
29	PAINTING			2000	574		20	15	15	15	29
30	DECORATING			2000	100		20	3	3	3	30
31	PAINTING			2000	226		20	6	6	6	31
32	CARPET BORDER			2000	46		20	1	1	1	32
33	DECORATING			2000	400		20	12	12	12	33
34	PAINTING			2000	690		20	18	18	18	34
35	WALL COVE BASE			2000	113		20	2	2	2	35
36	TOTAL (lines 4 thru 35)				$ 33,671	$ 32		$ 1,168	$ 1,136	$ 1,168	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING			2000	600		20	15	15	15	9
10	TILE			2000	7,764		20	162	162	162	10
11	PAINTING			2000	650		20	17	17	17	11
12	PAINTING			2000	800		20	20	20	20	12
13	WALL-BASE COVERING			2000	305		20	6	6	6	13
14	DECORATING			2000	308		20	11	11	11	14
15	WINDOW TREATMENT			2000	9,455		20	473	473	473	15
16	PAINTING			2000	400		20	7	7	7	16
17	WALLPAPER			2000	1,680		20	21	21	21	17
18	WALLPAPER			2000	1,995		20	8	8	8	18
19	PAINTING			2000	90		20	3	3	3	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 24,047	$		$ 743	$ 743	$ 743	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS-DEAUVILLE HEALTHCARE			1982	3,174		20			3,174	9
10	VARIOUS-DEAUVILLE HEALTHCARE			1983	22,098		20			22,098	10
11	VARIOUS-DEAUVILLE HEALTHCARE			1984	78,473	1,112	20	1,235	123	76,504	11
12	VARIOUS-DEAUVILLE HEALTHCARE			1985	65,697	3,416	20	3,458	42	52,769	12
13	VARIOUS-DEAUVILLE HEALTHCARE			1986	11,600	487	20	611	124	8,904	13
14	VARIOUS-DEAUVILLE HEALTHCARE			1987	17,548	557	20	557		7,520	14
15	VARIOUS-DEAUVILLE HEALTHCARE			1990	16,762	532	20	838	306	8,799	15
16	VARIOUS-DEAUVILLE HEALTHCARE			1991	36,643	1,163	20	1,833	670	18,256	16
17	VARIOUS-DEAUVILLE HEALTHCARE			1992	27,806	668	20	1,391	723	11,772	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 279,801	$ 7,935		$ 9,923	$ 1,988	$ 209,796	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 335,437	$ 17,658	$ 31,271	$ 13,613		$ 225,693	37
38	Current Year Purchases	43,439	9,911	2,637	(7,274)		2,637	38
39	Fully Depreciated Assets	269,442					269,442	39
40								40
41	TOTALS	$ 648,318	$ 27,569	$ 33,908	$ 6,339		$ 497,772	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	AUTO	1996	$ 25,000	$ 1,775	$	$ (1,775)	3	$ 25,000	42
43	FACILITY	AUTO	1999	18,800	5,000	5,000		3	6,045	43
44										44
45										45
46	TOTALS			$ 43,800	$ 6,775	$ 5,000	$ (1,775)		$ 31,045	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,802,650	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 48,483	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 69,299	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 20,816	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,001,635	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	EXCESS COST-96 AUTO	$ 32,231	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 32,231	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

DEAUVILLE NURSING HOME, INC.
0038612
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
DEAUVILLE NURSING HOME,INC.	172,500	17,658	17,250	(408)	71,187
DEAUVILLE HEALTHCARE CENTER	162,937		14,021	14,021	154,506
TOTALS	335,437	17,658	31,271	13,613	225,693

LINE 29: CURRENT YEAR

DEAUVILLE NURSING HOME,INC.	43,439	9,911	2,637	(7,274)	2,637
DEAUVILLE HEALTHCARE CENTER					
TOTALS	43,439	9,911	2,637	(7,274)	2,637

LINE 30: FULLY DEPRECIATED

DEAUVILLE NURSING HOME,INC.					
DEAUVILLE HEALTHCARE CENTER	269,442				269,442
TOTALS	269,442				269,442

TOTALS (Should Tie to Totals on Page 13)

DEAUVILLE NURSING HOME,INC.	215,939	27,569	19,887	(7,682)	73,824
DEAUVILLE HEALTHCARE CENTER	432,379		14,021	14,021	423,948
TOTALS	648,318	27,569	33,908	6,339	497,772

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 666 Description: PITNEY BOWES - POSTAL MACHINE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,347	$		$ 24,347	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,225			2,225	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			25,852			25,852	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				29,081		29,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program						160		160	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					911	7,325		8,236	13
14	TOTAL			$		$ 53,335	$ 36,566		$ 89,901	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	MEDICAL SUPPLIES	5,419
2	LABORATORY	1,906
3		
4		
5		
6		
7		
8		
9		
10		
		7,325

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	911
2		
3		
4		
5		
6		
7		
8		
9		
10		
		911

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 31,227	$ 31,227	1
2	Cash-Patient Deposits	44,262	44,262	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	775,909	775,909	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,123	31,123	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,540,795	8
9	Other(specify): See supplemental schedule	318,838	414,816	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,201,359	$ 2,838,132	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,934	13
14	Buildings, at Historical Cost		2,211,665	14
15	Leasehold Improvements, at Historical Cos	257,724	508,666	15
16	Equipment, at Historical Cost	283,015	707,737	16
17	Accumulated Depreciation (book methods)	(197,533)	(2,995,444)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		29,315	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 343,206	$ 657,873	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,544,565	$ 3,496,005	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,188	$ 226,188	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,262	44,262	28
29	Short-Term Notes Payable	509,013	509,013	29
30	Accrued Salaries Payable	107,837	107,837	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,292	17,292	31
32	Accrued Real Estate Taxes(Sch.IX-B)		212,384	32
33	Accrued Interest Payable		16,532	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	48,612	48,612	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 953,204	$ 1,182,120	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,803,488	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	3,746	3,746	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,746	$ 1,807,234	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 956,950	$ 2,989,354	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 587,615	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,544,565	$ #REF!	48

*(See instructions.)

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
EMPLOYEE ADVANCES	8,600	8,600
DUE FROM SUPERIOR	310,238	310,238
REAL ESTATE TAX ESCROW		95,978
	318,838	414,816

OTHER CURRENT LIABILITIES:	Amount	Amount
ACCRUED EXPENSES	15,657	15,657
DUE TO PUBLIC AID	32,786	32,786
UNION DEDUCTION	170	250
	48,613	48,693

OTHER NON CURRENT ASSETS:		
Construction In Progress		
MORTGAGE COSTS		1,000
INVESTMENTS		28,315
		29,315

OTHER NON CURRENT LIABILITIES:		
DEFERRED INCOME TAX	3,746	3,746
	3,746	3,746

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 754,368	1	
2	Restatements (describe):		2	
3	**Schedule attached**	37,670	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 792,038	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(204,423)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (204,423)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 587,615	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	DEAUVILLE NURSING HOME, INC. #	0038612	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		792,038
Adjustments:		
		-
		-
		-
INCOME-LAB (BLOOD GLUCOSE)		(32,270)
BAD DEBT EXPENSE		6,867
MANAGEMENT FEES		2,075
SPEECH THERAPY-PART B		(2,063)
INCOME TAX		(3,524)
LEGAL		(8,755)
Total adjustments		(37,670)
Balance - Beginning of Year		754,368
Equity(Deficit) from Page 17 Col 1		587,615
Related Party		
Equity(Deficit)	-253522	
Income	172557	
		(80,965)
Combined Equity - End of Year		506,650

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,636,022	1
2	Discounts and Allowances for all Levels	(147,812)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,488,210	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,304	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 110,304	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,079	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,429	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 37,508	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,521	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,521	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	387	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 387	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,647,930	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,842	31
32	Health Care	1,119,677	32
33	General Administration	1,077,860	33
	B. Capital Expense		
34	Ownership	670,140	34
	C. Ancillary Expense		
35	Special Cost Centers	120,033	35
36	Provider Participation Fee	81,801	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,852,353	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,423)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (204,423)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DEAUVILLE NURSING HOME, IN # 0038612 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	REAL ESTATE TAX REFUND	387
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	387

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,384	1,528	$ 38,130	$ 24.95	1
2	Assistant Director of Nursing	2,143	2,215	43,776	19.76	2
3	Registered Nurses	12,378	15,427	250,005	16.21	3
4	Licensed Practical Nurses	8,619	9,244	147,830	15.99	4
5	Nurse Aides & Orderlies	64,286	68,362	360,764	5.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,253	4,922	46,528	9.45	8
9	Activity Director					9
10	Activity Assistants	6,206	6,484	46,930	7.24	10
11	Social Service Workers	4,875	6,019	34,631	5.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,315	19,216	151,121	7.86	15
16	Dishwashers					16
17	Maintenance Workers	3,852	4,060	36,971	9.11	17
18	Housekeepers	13,035	13,965	81,854	5.86	18
19	Laundry	4,968	5,406	32,894	6.08	19
20	Administrator	1,984	2,192	41,946	19.14	20
21	Assistant Administrator	891	969	25,769	26.59	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,529	6,429	89,100	13.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,702	1,979	17,611	8.90	31
32	Other Health Care(specify)					32
33	Other(specify)	1,231	1,282	30,133	23.50	33
34	TOTAL (lines 1 - 33)	154,651	169,699	$ 1,475,993 *	$ 8.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 5,015	1-3	35
36	Medical Director	MONTHLY	5,200	9-3	36
37	Medical Records Consultant	MONTHLY	3,984	10-3	37
38	Nurse Consultant	49	2,450	10-3	38
39	Pharmacist Consultant	MONTHLY	1,547	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	60	2,971	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	74	4,100	11-3	44
45	Social Service Consultant	52	5,759	12-3	45
46	Other(specify)				46
47	REHABILITATION	49	1,890	10A-3	47
48					48
49	TOTAL (lines 35 - 48)	284	$ 32,916		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,848	$ 64,674	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,848	$ 64,674		53

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING SALARIES	1,231	1,282	$ 30,133	$ 23.50
	1,231	1,282	$ 30,133	$ 23.50

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY DONAHUE	ADMIN	NONE	$ 41,946
LORRY DEINO	ASST ADMIN	NONE	25,769
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,715

B. Administrative - Other

Description	Amount
DAN SHABAT-MGT FEE	$ 235,327
PRO HEALTH-MGT FEE	6,480
TOTAL (agree to Schedule V, line 17, col. 3)	$ 241,807
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FUTURE ASSOCIATES	ADMINISTRATIVE	$ 54,000
FR&R	ACCOUNTING	55,372
SCHARTZ, LAWRENCE	LEGAL	450
EUGENE GRIFFIN	LEGAL	8,864
SACHNOFF & WEAVER	LEGAL	1,005
TENNEY & BENTLEY	LEGAL	194
VARIOUS-SEE ATTACHED	COMPUTER SUPPORT	13,173
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	885
ECONOCARE	PURCHASING CONSLT	2,952
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 136,895

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,964
Unemployment Compensation Insurance	10,331
FICA Taxes	111,298
Employee Health Insurance	55,583
Employee Meals	30,085
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	3,840
HOLIDAY EXPENSE	7,757
PENSION CONTRIBUTION	7,824
TOTAL (agree to Schedule V, line 22, col.8)	$ 247,682

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,639
Health Care Worker Background Check	
(Indicate # of checks performed 11)	124
PROMOTIONAL ADVERTISING	8,830
IL COUNCIL ON LONG TERM CARE	5,583
LICENSES AND FEES	2,122
CONTRIBUTIONS & ENTERTAINMENT	11,248
LESS:CONTRIBUTIONS &ENTERTAIN	(11,248)
Less: Public Relations Expense	( )
Non-allowable advertising	(8,830)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,668

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,483
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,483

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEAUVILLE NURSING HOME, INC. # 0038612 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NURSES AIDES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC-5583**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,905** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **NA**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
DEAUVILLE HEALTHCARE CENTER, 38612, 11/1/92

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **81,801**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NA** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **30,085** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ NA

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **NA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NA** If no, please explain. **NA**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw